GEORGIA DEPARTMENT OF DRIVER SERVICES
MEDICAL REPORT

PATIENT INSTRUCTIONS

IMPORTANT:

1. Complete, date, and sign **page 1** of this report.
2. Give **pages 1-4** to your licensed physician.
3. The physician must complete, date, and sign **pages 2-4**.
4. **All pages** of this report MUST be mailed or faxed (with coversheet) by a licensed physician directly to:

Department of Driver Services
Medical Review Unit
P. O. Box 80447
Conyers, Georgia 30013 or
Fax to (770) 344-3629

PATIENT INFORMATION

Name: Last _____ First _____ MI ____ DOB (mm/dd/yyyy): _____

Physical Street Address: _____

City _____ State _____ Zip Code _____ Driver's License # _____

PATIENT HISTORY

Please check "Yes" or "No" to each of the following questions. Explain each "yes" answer if your ability to drive is OR could be affected.

Yes	No	
☐	☐	Physical impairments
☐	☐	Driver's license has ever been revoked or denied
☐	☐	Neurological problems or diseases
☐	☐	Head or spinal injuries
☐	☐	Seizures, fits, blackouts, convulsions, or fainting spells
☐	☐	Nervous, mental or psychiatric problems or diseases
☐	☐	Cardiovascular problems or diseases
☐	☐	Orthopedic, musculoskeletal, bone, joint or muscle problems or diseases
☐	☐	Diabetes
☐	☐	Visual problems or diseases
☐	☐	Hearing problems

Explain any "Yes" answer(s):

_____

_____

PATIENT ATTESTATION

I hereby swear or affirm that the above answers are true to the best of my knowledge. I authorize _____, a licensed physician, to complete this examination and to provide further clarification or information about my medical condition to the Georgia Department of Driver Services (DDS). I agree that this Medical Report may be submitted to the DDS Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State of Georgia, and that it may also be used for the guidance of the courts when necessary.

_____ _____

Driver/Licensee Signature **Date**

Patient Name: Last: First: M.I.:

MEDICAL REPORT PHYSICIAN'S STATEMENT

GENERAL INFORMATION:

1. How long has this individual been under your care as a patient? Years: Months:

2. When did you last examine this patient? Year: Month:

3. Does this patient have a problem, condition, disorder or disease that could affect his or her ability to drive safely?
☐ Yes ☐ No If 'Yes', please explain:

4. Does this patient require adaptive equipment in order to drive? ☐ Yes ☐ No If 'Yes', please explain:

5. What is your diagnosis?

*****IMPORTANT: Questions 6 and 7 REQUIRE a 'YES' or 'NO' answer.*****

6. Do you find any difficulties, problems, or diseases, other than 1 through 5 above, which would interfere with this person's ability to safely operate a motor vehicle? ☐ Yes ☐ No If 'yes', please explain:

7. In your opinion, is this patient medically capable of safely operating a motor vehicle? ☐ Yes ☐ No If no, please explain:

SECTION A

NEUROLOGICAL, CEREBROVASCULAR, ALTERATION IN CONSCIOUSNESS

A. 1. Does patient have a history of blackouts or fainting spells? ☐ Yes ☐ No

If yes, how often? Date of last occurrence:

Was this a one-time episode? ☐ Yes ☐ No If yes, state the cause.

A. 2. Has patient had seizures associated with epilepsy? ☐ Yes ☐ No

If 'yes', date of onset and history:

What is the Frequency: Date of last occurrence:

A. 3. Has patient had convulsive seizures not associated with epilepsy? ☐ Yes ☐ No

If 'yes', date of onset and history:

What is the Frequency: Date of last occurrence:

A. 4. Is patient compliant with medication regiment? ☐ Yes ☐ No

A. 5. Should patient continue taking medication? ☐ Yes ☐ No

A. 6. Was an electroencephalogram performed? ☐ Yes ☐ No (If yes, please attach copy of EEG report.)

A. 7. Parkinson's disease? ☐ Yes ☐ No Coordination normal? ☐ Yes ☐ No Vertigo? ☐ Yes ☐ No

Explain any 'Yes' answers for question A.7.

A. 8. Any other neurological or cerebrovascular conditions which could affect patient's ability to safely operate a motor vehicle?
☐ Yes ☐ No

If 'yes', please explain:

☐ If this box is checked, a neurological evaluation report must be made by a neurosurgeon or neurologist and attached to this report.

Patient Name: Last: First: M.I.:

SECTION B

CARDIOVASCULAR, RESPIRATORY OR HYPERTENSIVE DISEASE

Functional Capacity (American Heart Association (AHA)):

- Class 1: No limitation physical activity
- Class 2: Slight limitation physical activity
- Class 3: Marked limitation physical activity
- Class 4: Complete limitation physical activity

B. 1. Functional capacity classification (Check one): ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4

B. 2. Blood pressure: _____

B. 3. Edema: ☐ Yes ☐ No

B. 4. Dyspnea and/or angina? ☐ Yes ☐ No At rest? ☐ Yes ☐ No Slight exertion? ☐ Yes ☐ No Moderate? ☐ Yes ☐ No

B. 5. Any syncope? ☐ Yes ☐ No If 'yes', please indicate frequency and severity:

_____

_____

B. 6. Any syncopal episodes in the past 12 months? ☐ Yes ☐ No If 'yes', please explain:

_____

_____

B. 7. Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

B. 8. Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle?
If 'yes', please explain: _____

_____

SECTION C

NERVOUS, MENTAL, PSYCHIATRIC, PSYCHOLOGICAL

C. 1. Any nervous, mental, psychiatric or psychological problem that could impair driving ability? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

C. 2. Memory within normal limits? ☐ Yes ☐ No

C. 3. History of frequent or intermittent confusion? ☐ Yes ☐ No

C. 4. Any evidence of organic brain syndrome? ☐ Yes ☐ No

C. 5. Any other findings or nervous, mental psychiatric or psychological which could affect patient's ability to operate a motor vehicle safely? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

☐ If this box is checked, a psychiatric evaluation report must be made by a psychiatrist or psychologist and be attached to this report, with recommendations.

Patient Name: Last: First: M.I.:

SECTION D

ORTHOPEDIC, MUSCULOSKELETAL

D. 1. Explain any limitation of motion: _____

_____

D. 2. Any stiff or flail joints? ☐ Yes ☐ No

D. 3. Any spastic or paralyzed muscles? ☐ Yes ☐ No If 'yes', where?

_____

D. 4. Does patient use or need orthopedic appliances or supports? ☐ Yes ☐ No If 'yes', please explain:

_____

D. 5. Any other orthopedic or musculoskeletal findings which could affect patient's ability to safely operate a motor vehicle?

☐ Yes ☐ No If 'yes', please explain: _____

SECTION E

DIABETES

E. 1. Age at onset: _____

E. 2. Is diabetes well-controlled? ☐ Yes ☐ No Please explain response:

_____

E. 3. Has patient ever been in a diabetic coma? ☐ Yes ☐ No If 'yes', date of last coma: _____

Warning symptoms? _____

E. 4. Has patient ever had an episode involving loss of consciousness or near-loss of consciousness? ☐ Yes ☐ No

If 'yes', please explain cause and date of last episode: _____

SECTION F

MEDICATION

F. 1. Is the patient prescribed medication? ☐ Yes ☐ No

F. 2. If 'yes', is the patient taking medication as prescribed? ☐ Yes ☐ No

If 'yes', please indicate name, dosage and frequency for each medication: _____

_____

_____

If 'no', please describe medications the patient is not compliant with: _____

_____

PHYSICIAN ACKNOWLEDGEMENT

Name of Practice _____

Physician Full Name: Last: _____ First: _____ M.I. _____

Physician Specialty: _____

License Number/State _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Telephone Number: _____ - _____ - _____

_____ _____

Physician Signature **Date**